





# Health Professions Education Program

Scholarship & Loan Repayment Application

HEALTH PROFESSIONS
EDUCATION FOUNDATION

Giving Golden Opportunities

# Giving Golden Opportunities by:

Increasing the supply of health professionals practicing in underserved areas

Improving access to healthcare in rural and urban underserved areas of California

Helping students to pursue a career in the health professions

Awarding health professionals who are dedicated to practicing in underserved communities.

### **Application Instructions**



The Health Professions Education Program offers two types of awards: the Health Professions Education Loan Repayment and the Health Professions Education Scholarship. The purpose of these awards is to increase the number of health professionals practicing in the medically underserved areas of California.

Applications for the Health Professions Education Program are accepted once a year.

Any monies awarded under this program are intended to pay or repay tuition, required fees, books, supplies, and educational equipment costs related to the applicant's health professional education. All awards are subject to the availability of funding.

#### **Selection criteria**

Selection for the Health Professions Education awards is based solely on information contained in the application and supporting documentation. Selection for awards is based on the following criteria:

Work Experience—experience providing direct patient care in a medically underserved area (MUA). Financial Need—actual or potential difficulty in completing education in the absence of an award. Career Goals—professional goals for the next five to ten years.

**Community Service**—documented volunteer service and/or activities, particularly in a MUA.

**Community Background**—family structure and community where you grew up: for example, rural, inner city/urban, suburban, or MUA.

**Academic performance**—prior and current performance and potential for future academic success.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted. Only complete applications will be evaluated. The Foundation will not notify individuals if their application is incomplete.

#### LOAN REPAYMENT GRANTS

The Health Professions Education Loan Repayment Program repays up to \$20,000 in educational debt that was incurred while attending a health professional education program. In return for the loan repayment, the awardee must agree to practice direct patient care in a medically underserved area for a minimum of 2 years

#### Loan repayment eligibility

Loan repayment is available to currently licensed health professionals. Awardees must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

**Be a graduate of** one of the following health professional education programs:

- Dentistry
- Dental Hygiene
- Nurse Practitioner
- Certified Nurse Midwifery
- Physician Assistant

Complete a 2-year service obligation to practice your profession in a MUA providing direct patient care; While completing the service obligation, work a minimum of 32 hours per 5 day period or work week; and Be a U.S. citizen or permanent resident and a California resident.

#### **Loan Repayment Application**

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

#### Submit the following:

1. One (1) official transcript with your health professional degree posted. The transcript must be marked official by the school and submitted to the Foundation in a sealed envelope. If the school does not release official transcripts to the student, the transcript may be sent directly from the school to the Foundation. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in a broken envelope.

Your health professional degree must be posted on the transcript unless you are a student in the final year in a course of study leading to a health professional degree. If you are in the final year of the program, submit the most current transcript(s) that illustrate your health professional education to date..

- \*Loan repayment applicants must also submit two (2) photocopies of their application and 2 photocopies of the following supporting documents (items 2 through 5).
- 2. Personal Statements. Attach your personal statements to the application. Your statements must be typed. Statements may be short or long. However, please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.
- **3. Two letters of recommendation.** Letters must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.



- **4. Employment Verification Form.** This form must be signed by an official in your personnel department. The Employment Verification Form is enclosed as part of the application. Applicants can also download this form from the Foundation's Web site at <a href="https://www.healthprofessions.ca.gov">www.healthprofessions.ca.gov</a>.
- **5. 2002 Federal tax return with all W-2s.** Applicants who do not apply for financial aid must submit complete copies of their 2002 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

#### SCHOLARSHIP APPLICANTS

Students may receive up to \$10,000 for the **Health Professions Education Scholarship**. Scholarships are funded for one academic year, usually 2 semesters or 3 quarters.

#### **Scholarship Eligibility**

To be eligible for a scholarship, students must sign a contract with the Office of Statewide Health Planning and Development and agree to the following terms:

**Be enrolled or accepted** to one of the following health professional education programs:

- Dentistry
- Dental Hygiene
- Nurse Practitioner
- Certified Nurse Midwifery
- Physician Assistant

**Complete a 2-year service obligation** to practice your profession in a MUA providing direct patient care;

Be a full-time or part-time student (no less than 6.0 units) in an California accredited school;

Maintain a minimum cumulative GPA of 2.0 each year scholarship funds are sought; and

Be a U.S. citizen or permanent resident and a California resident

#### **SCHOLARSHIP APPLICATION**

Applications must be postmarked by the deadline. Only complete applications will be reviewed. Each part of the application must be completed. All supporting documentation must be submitted. The Foundation will not notify applicants if their application is received incomplete. Applicants are urged to contact the Foundation prior to the final filing date to verify if their application was received complete. Do not bind or submit applications in a loose-leaf binder.

#### Submit the following:

1. One (1) official transcript related to your health professional education. If you are a student in your first year of the health professional education program and your transcripts do not reflect your health professional education, submit your most current transcript.

The transcript must be marked official by the school and delivered to the Foundation in a sealed envelope. The Foundation will not accept unofficial transcripts, copies or

print outs of transcripts, or transcripts in a broken envelope.

- \*Students must also submit two (2) photocopies of their application and 2 photocopies of the following supporting documents (items 2 through 5)
- 2. Personal Statements. Attach your personal statements to the application. Your statements must be typed. Statements may be short or long. However, please limit all Personal Statements to not more than 6 pages. Restate and number each question along with your answer.
- **3. Two letters of recommendation.** Letters of recommendation must be current or dated within the last six months of the application deadline. The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a faculty member.
- **4. Graduation Date Verification Form**. The health professional education program director or faculty members authorized to sign on the director's behalf must sign this form. The Graduation Date Verification Form is enclosed as part of the scholarship application. Applicants can also download this form from the Foundation's Web site at <a href="https://www.healthprofessions.ca.gov">www.healthprofessions.ca.gov</a>.
- **5. Student Aid Report (SAR).** Students must submit the final 2003-2004 SAR. The SAR must indicate the student's expected family contribution (EFC). The FAFSA is available from all college financial aid offices and is also available on the Internet at <a href="https://www.ed.gov/offices/OPE/express.html">www.ed.gov/offices/OPE/express.html</a>.

Or

**2002** Federal tax return with all W-2s. Applicants who do not apply for financial aid must submit complete copies of their 2002 Federal tax return with all W-2s. Do not submit State tax returns. State tax returns will not be accepted in lieu of the Federal tax return.

Ineligibility for Health Professions Education Awards
Applicants who owe a conflicting service obligation to
practice direct patient care to another entity entered into
before filing an application with the Foundation will be
ineligible to receive a loan repayment grant or scholarship.

#### **Notification of awards**

The Foundation will notify applicants of their application results within eight weeks of the final filing date.

**APPLICATION POSTMARK DEADLINE: March 26, 2003** 

Submit applications to: Health Professions Education Foundation 818 K Street, Suite 210 Sacramento, CA 95814 (800) 773-1669 or (916) 324-6500



Reviewed By:



PART A – PERSONAL INFORMATION	List any languages you can speak, read, and write in addition		
(Please type or print your answers in the space provided)	to English: Check all that apply.		
Please indicate which award you are applying for:	1 Speak Read Write		
☐ Health Professions Eduction Loan Repayment ☐ Health Professions Eduction Scholarship	2 Speak Read Write		
Please enter the loan repayment or scholarship amount you are requesting: \$	Are you a citizen or permanent resident of the U.S.? ☐ Yes ☐ No Are you a California resident? ☐ Yes ☐ No		
Do you owe an existing service obligation to another entity?  Yes No  If yes, please explain.	PART <b>B</b> – <b>WORK EXPERIENCE</b> Please list all paid and/or unpaid work experience you may have had. List most recent first. Attach additional sheets as needed.		
	Employer's Name		
Are you a previous awardee of the Foundation? $\square$ Yes $\square$ NO	Address		
If yes, please enter the contract#:	City State Zip		
	County		
Name	Your Supervisor's Name:		
Mailing Address	Office Phone:		
County State Zip	Your Position/title: Monthly Salary:		
County Permanent Address	Paid worker OR None paid Full-time OR Part-time		
City State Zip	Employment Start Date// Employment End Date//		
County			
Home Phone Work Phone	Average hours worked (please choose only one):/day/week/month		
Social Security #: CA Drivers License #	Brief description of your job duties:		
Date of birth:/ Age: Gender: Date Date of birth:/ Age: Gender: Date Date Date Date Date Date Date Date			
Marital Status: Unmarried Married			
Number of dependents other than self and spouse:	Employer's Name		
Are you currently employed as a licensed health professional?	Address		
☐ Yes ☐ No	City State Zip		
If yes, provide license # Expiration date/	County		
Expiration date	Your Supervisor's Name: Office Phone:		
Are you the first in your family to attend college? $\square$ Yes $\square$ No	Your Position/title: Monthly Salary:		
Which best describes your ethnic background:	☐ Paid worker <b>OR</b> ☐ None paid ☐ Full-time <b>OR</b> ☐ Part-time		
Asian American African American Caucasian			
Hispanic/Latino Native American Pacific Islander	Employment Start Date// Employment End Date//		
Other (Please specify)	Average hours worked (please choose only one):/day/week/month		
If Native American, please specify tribal affiliation:	Brief description of your job duties:		
	AL USE ONLY.		
Recd:   Compl / Inc:   Applinguiry: ( ) ( )	Omitted: A/Pgs GDV EVF SAR TAX LoR Oth:  HPEF Contact: for:		
Input by: MUA: Yes / No	CT#		

Comments:



#### PART C - BACKGROUND PART **F** – **APPLICATION CERTIFICATION** For each age category below, list the city, county, and state you grew up in. Check all I certify that all information in this application is true and accurate to items that best describe your socioeconomic background. the best of my knowledge. I authorize the Health Professions Education Foundation to verify any information submitted as part of Inner City/Urban Suburban Middle-class Poor **Age Category** Rural this application. I understand that falsification of information con-Birth-10 years tained in this application will disqualify my application. County: State: I also understand that if falsification is discovered after I have been Inner City/Urban Suburban **Age Category** Rural Poor Middle-class awarded, I will be required to repay all funds awarded, plus interest 10-20 years and administrative fees. State: County: I also understand that my personal statements and pictures become Inner City/Urban Suburban Poor Middle-class **Age Category** Rural the rights of the Health Professions Education Foundation and may be 20-30 years used, including but not limited to, advertising/marketing, program State: County: reports, newsletters, and other publications. **Age Category Rural** Inner City/Urban Suburban Poor Middle-class 30-40 years Printed name (last name, first name, middle initial) State County: Inner City/Urban Middle-class **Age Category Rural** Suburban Poor 40+ years City:\_\_ County: Applicant's Signature \_\_\_\_\_ Date PART **D** – QUESTIONNAIRE **SUBMIT APPLICATIONS TO:** Where did you hear about the Health Professions Education Program?(Check all that apply) **Health Professions Education Foundation** School Work (employer or co-worker) Friend/Acquaintance **Health Professions Education Program** Foundation Web site Other Web site Advertisement TV Radio 818 K Street, Suite 210 Newspaper or publication (please specify) Sacramento, CA 95814 Organization or Affiliation (please specify) Other source (please specify) \_\_\_ Postmark DEADLINE March 26, 2003 Where did you receive the Health Professions Education Program application form? **APPLICATION CHECKLIST** (Loan Repayment Application) ☐ Financial Aid Office ☐ Program Director/Instructor ☐ Foundation office ☐ 1. One (1) official transcript with Health Professions degree posted. Foundation Web site Other Web site Work (employer/co-worker) **2. Personal Statements**. Friend/Acquaintance ■ 3. Two letters of recommendation. Other please specify \_\_\_ 4. Employment Verification Form. ☐ 5. 2002 Federal tax return with all W-2s. PAKI **E** – **PERSONAL STATEMENTS** Attach your personal statements to the application. Your statements must be typed. ☐ 6. Two copies of the original application and the attachments (items 2-5). Do not make photocopies of transcripts. Restate and number each question along with your answer. 1. Briefly describe the community/ies in which you were raised through age 18. [For each community, please specify whether it was: a) rural, urban, suburban, inner city, Indian Reservation, etc.; b) the socioeconomic level (for example, poor, middleclass, APPLICATION CHECKLIST (Scholarships) etc.); and c) adverse conditions.] $\square$ 1. One (1) official transcript related to your 2. Briefly describe your family upbringing, any challenges you faced, and how you health professions education. overcame them? 2. Personal Statements. 3. How is your community background relevant to your career interests? 3. Two letters of recommendation. 4. What are your health professional goals for the next 5-10 years and what lead you to 4. Graduation Date Verification Form. choosing this career path?

■ 5. Student Aid Report (SAR).

 6. Two copies of the original application and the attachments (items 2-5). Do not make photocopies of transcripts.

6. Is there anything else you would like to tell us about yourself?

5. Please describe your need for a scholarship or loan repayment award, and/or explain any changes in your household income since January 1, 2002.

## **Graduation Date Verification Form**



\*Must be completed by the program director or the director's designee.

The student named below is applying for a scholarship from the Health Professions Education Foundation. This form is required for the application to be considered. Please return this form to the Foundation with original signature.

Applicant's Name:

Health Professional Educational Program:	
Address:	
Year Entered:Expected Gr Month/Year	aduation Date: Month/Year
Please comment on the student's performance	and potential for academic success.
Name (Please Print)	Title
Signature	Date
Phone Number ( )	
Please check one:  ☐ I certify that I am the Program Director  ☐ I certify that I am authorized to sign the behalf of the Program Director.	

## **Employment Verification Form**



(For Loan Repayment Applicants Only)
ATTENTION!This blank form may be duplicated, however, to be acceptable, the completed form must bear an original ink signature. Photocopies and faxed copies of the completed form are not acceptable.

EMPLOYMENT VERIFICATION FORM (TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT)

Employee's Name:				
Date of Hire:	Position Title: _	1	Monthly Salary:	
Employer:		Employee's Supervisor:		
Title:		Telephone Number:		
Employer's Address:				
City		State	Zip Code	
County				
Additional Comment				
This form was comp	leted by:			
Name:		Telephone Number:		
Title:				
Signature:		Date:		

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